Primary Care Demonstration Project

Policy *and* Information Guide

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The Primary Care Demonstration Project (PCDP) is a three-year research project that is testing new and innovative ways of delivering primary health care. The project is jointly sponsored by the B.C. Ministry of Health and the Health Canada Transition Fund.

For more information contact
PCDP@moh.hnet.bc.ca

or visit the PCDP website at:
http://www.hlth.gov.bc.ca/care/primdemo/index.html

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Practice Funding

Blended funding uses a population-based funding method, while maintaining a fee-for-service component for certain types of medical services, and for certain types of patients.

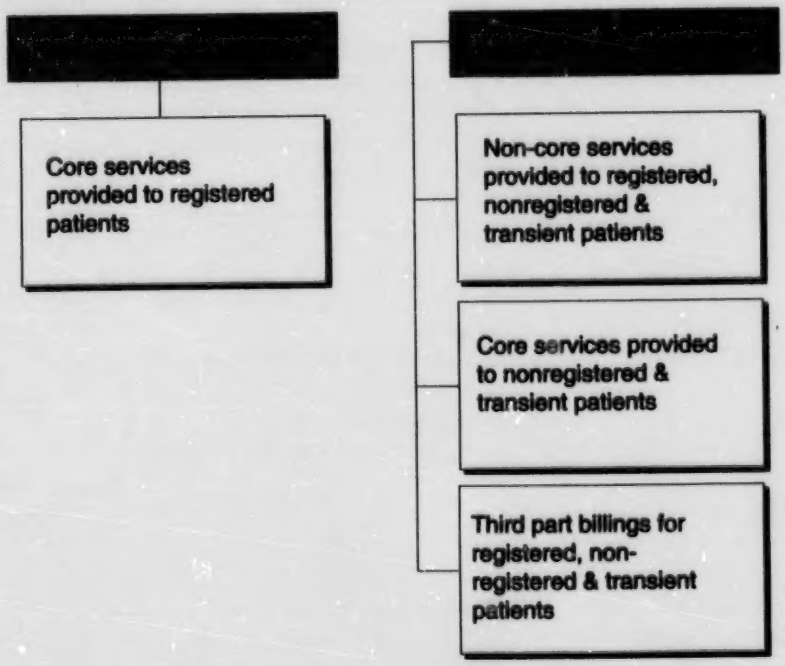
"Core" services refer to a specific set of medical services that most GPs typically provide as part of comprehensive primary care delivery. All other GP services, including anaesthesia, obstetric, and emergency services, are "non-core" services.

"Registered patients" are patients who live in the practice's catchment area and who receive the majority of their primary care from the practice. Practices receive population-based funding for "core" services they provide to registered patients. Payment for non-core services to registered patients remains fee-for-service.

Physicians may direct bill patients only for services that are not a benefit established under the Medical Services Commission. Direct billings must be in accordance with the guidelines established by the Medical Services Commission and the Medical Services Plan.

The population-based funding does not involve "fund holding"' and therefore the use of services provided by specialists, diagnostic testing, and prescription drug utilization will not affect the amount of population-based funding a practice receives.

Blended Funding


Core services provided to registered patients
Non-core services provided to registered, nonregistered & transient patients
Core services provided to nonregistered & transient patients
Third part billings for registered, non-registered & transient patients

Calculation of Population-Based Funding

The majority of income that a practice receives is population-based. In order to provide fair and reasonable compensation, the population-based funding is adjusted based on patient age, sex, and need for medical services. Need for medical services is adjusted using the Johns Hopkins Adjusted Clinical Group (ACG) case-mix adjustment system. (For more information about the Johns Hopkins Adjusted Clinical Groups, visit their web site: http://www.acg.jhsph.edu).

The ACG assigns patients to illness burden categories. Each of the 82 ACG categories has a specific yearly payment rate, with higher rates being paid for patients with greater illness burden.

The payment rates for each of the ACG categories were developed specifically for British Columbia. This was done by assessing the health status of British Columbia's 3.7 million patients with Medical Services Plan (MSP) coverage through an analysis of the previous year's MSP service utilization data (specifically, ICD-9 data). Based on this analysis, each patient was then placed into one of the 82 ACG categories.

The next step was to determine the payment rate for each ACG category through a review of the previous year's fee-for-service claims. First, the total fee-for-service payment for core services provided to each person in the ACG category was calculated. Second, the average of the total fee-for-service payments for each ACG category was then calculated. Finally, the average fee-for-service payment for an ACG category was used as the provincial payment rate per category.

The total amount of population-based funding for an individual GP practice is developed by assigning each of the practice's registered patients to an ACG category (based on an analysis of their previous year's service utilization/ICD-9 codes). The provincial payment rate for each of the patients, in every cluster, is then added up. The total is the practice's annual population-based income. The population-based funding is then allocated quarterly in order to ensure that the funding received accurately reflects the practice's patient population.

Funding Adjustments

A practice's population-based funding is calculated based on the number of patients registered with the practice, their health status, and the extent to which they received core services from outside of the practice. As such, the annual population-based funding is recalculated (and allocated) quarterly in order to adjust for any changes that would affect the amount of population-based funding that the practice receives.

For example, during a specific quarter, a practice might have added new patients to its patient register, and some patients may no longer

Practice Funding

What is a practice catchment area?

It consists of the Local Health Area in which the practice is located, and any adjacent local Health Area from which patients can reasonably be expected to use the practice as their main source of primary care.

Patients who live in the practice's catchment area, but do not receive the majority of their primary care from the practice are considered "nonregistered" patients. Patients who do not live in the practice's catchment area, and do not receive the majority of their primary care from the practice are considered "transient" patients. Practices are paid fee-for-service for core and non-core services they provide to nonregistered and transient patients.

How were the "Core Services" identified?

A review of the B.C. Ministry of Health fee-for-service claims data identified 233 fee items that accounted for over 99% of all general practitioner billings in B.C. Of these fee items, those pertaining to anaesthesia, obstetric and emergency services were removed as these are not medical services that all general practitioners provide. The remaining 76 fee items are core services that all general practitioners are expected to provide as part of comprehensive primary health care delivery.

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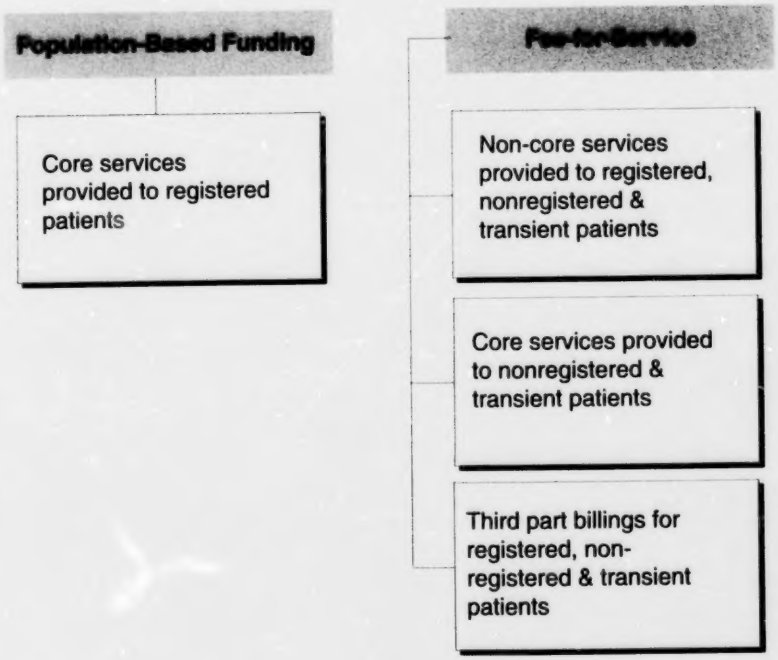
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For example, during a specific quarter, a practice might have added new patients to its patient register, and some patients may no longer

In order to adjust for any changes in a patient's health status, at the end of the year the process of assigning all the registered patients to an ACG payment category will be repeated.

The practice's total income consists of the population-based funding and any fee-for-service payments or third party billings. Payments to the practice are made twice a month. Decisions on how to allocate the income generated by the practice is a decision that is internal to the practice/contractor.

Service outflows include any fee-for-service claims for core services provided to registered patients by one of your own practice's physicians who is using an MSP payee number that is different from the one belonging to the practice.

be registered with the practice because they now receive the majority of their primary care elsewhere. Such changes will be assessed at the end of each quarter, and the funding instalment for the next quarter will be adjusted to reflect the changes to the practice's current patient register.

When a patient is added or removed from the patient register after the start of a quarterly period, the payment rate received will be based on the number of days that the patient was actually registered with the practice during the quarter (see section on Updating the Practice's Patient Register for more information on adding and removing patients from the practice's patient register).

The practice will receive 100% of the population-based payment rate for each registered patient (and payments will be made in quarterly installments). However, if a registered patient receives *core services* from another practice located in the same practice catchment area, the fee-for-service payment(s) made to the other practice will be deducted from the population-based funding payment that the practice will receive in the next quarter.

On an annual basis, the practice will not lose more money on service outflows than the registered patient's ACG payment rate. Once a registered patient's annual payment rate has reached $0.00 due to service outflows, no additional deductions will be made to cover the fee-for-service payments that were made to another practice for the core services they provided to the registered patient.

Calculating Service Outflows

It is not possible to know in advance the amount of service outflow that will occur in an upcoming quarter. As such, service outflows for the upcoming year are estimated, and then the population-based funding a practice receives each quarter is adjusted to reflect the service outflows that actually occurred.

Specifically, the difference between the estimated outflows for a quarterly period and the actual outflows is calculated. Funding owed to the practice (when outflows were overestimated) or funding owed back to the Ministry (when outflows were underestimated) will be added or subtracted from the population-based funding payment the practice will receive in the next quarter. This is known as an *"outflow adjustment"*.

How Quarterly Service Outflows are Estimated and Adjusted:

Step 1 The practice's registered patients are identified (See Section on Creating a Patient Register).

Step 2 The practice's population-based funding for the previous year is calculated based on the practice's patient register.

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How Quarterly Service Outflows are Estimated and Adjusted:

Step 1 The practice's registered patients are identified (See Section on Creating a Patient Register).

Step 2 The practice's population-based funding for the previous year is calculated based on the practice's patient register.

Step 3 Service outflows are estimated by taking the total number of core services that were provided to the practice's registered patients in the previous year by other practices located in the same catchment area. This number is then divided by the population-based funding calculated for the previous year. This results in an estimated percentage outflow.

Step 4 The practice's population-based funding for the upcoming year is then calculated based on the practice's patient register.

Step 5 The estimated percentage outflow is then multiplied by the estimated population-based funding for the upcoming year to give the estimated outflow dollar amount for the upcoming year.

Step 6 The estimated outflow dollar amount is then subtracted from the ACG population-based funding estimated for the upcoming year to give the total population-based funding the practice can expect to receive for the upcoming year.

Step 7 The population-based funding is then paid out in quarterly instalments. Quarterly instalments are used in order to enable the Ministry of Health to adjust the population-based funding so that it accurately reflects the actual service outflows that occurred during the quarter. This is discussed next.

Service Outlfow Adjustment

Q: *The extent to which registered patients receive "core services" from other practices may be different each quarter, and even change overtime. How do you ensure that the "expected outflow estimates" take into account any changes in patient use of other practices for their primary care?*

A: The expected outflows for an upcoming quarter are estimated using the most recent patient service utilization data. That is, the outflow estimate for the upcoming quarter is based on patient service utilization for the four three-month periods that directly preceded the current quarter. Using data from the four most recent quarters will provide the most up-to-date picture of the practice's service outflow patterns.

Example of a Service Outflow Adjustment

YEAR	PERIOD	ACTUAL OUTFLOW	TOTAL ACG PAYMENT
1	quarter 1	$5	$20
1	quarter 2	$4	$25
1	quarter 3	$6	$22
1	quarter 4	$5	$21
2	quarter 5	$?	$27

(total ACG payment is exclusive of outflows)

The estimated outflow percentage for the upcoming quarter is:
(5/20 + 4/25 + 6/22 + 5/21) / 4 = 23%.

In this example, population-based funding is $27 for the next quarter. This means that the "estimated outflow" for that quarter would be:
($27) (.23) = $6.21

In summary, the practice will receive population-based funding of $27.00, minus the estimated outflow of $6.21 for the quarter. Therefore, quarterly payment will be $20.79 ($27 - $6.21). The bimonthly payment would be $3.47 (20.79/6 weeks).

Outflow Adjustment

Consider the above practice at the start of Quarter 2 (Year 2). Looking back at the first quarter of Year 2, we find that outflows were only $6.

This means that our estimate was 21 cents too high ($6.21-$6.00 = $0.21). This 21 cents will be returned to the practice by subtracting it from the outflow estimate for Quarter 2 (Year 2). The .21 cents ($6.21-$6.00) is the "outflow adjustment".

Questions and Answers

Q: *Our practice has some patients who are sicker than others. Will the ACG payment rate compensate us for taking care of these patients?*

A: Yes. The population-based funding rate per each patient is based on their illness burden, with sicker patients having a higher payment rate.

Q: *What happens if our practice provides core services to a nonregistered patient?*

A: The practice will receive 100% of the fee-for-service payment for *only* the first two core services provided to a patient during a consecutive six-month period (the six-month intervals are January to June, and July to December). The practice will then receive 50% of the fee-for-service payment for any additional core services provided to the nonregistered patient within the six-month period.

You may want to consider adding a nonregistered patient to your patient register (and receive population-based funding for the patient) if you feel that s/he is receiving the majority of their primary care from your practice.

Q: *Patients are assigned to an ACG payment category according to their illness burden. What happens if I register a new patient for whom no ICD-9 information is available?*

A: For patients who cannot be assigned to an ACG category due to a lack of ICD-9 data, the payment rate will initially be set on the basis of an age/sex adjustment. The patient's ACG classification will be then be determined six months following their registration with the practice. At this time, the practice will then receive whichever funding is greater (i.e., the age/sex adjusted rate or ACG health status adjusted rate) for the remainder of the year.

Q: *What happens if a nonregistered patient becomes registered with our practice during the quarter, but the practice had already provided one or more core services to that patient during the quarter and billed fee-for-service?*

A: First, the effective date of patient registration will be backdated to the date that the first consecutive service was provided by the practice. Then, any fee-for-service payments that were made to the practice for core services they provided to the patient will be deducted from the population-based funding that the practice receives. However, this deduction will never exceed the patient's population-based payment rate for the year.

Q: *What happens if one of our practice's physicians works outside of our practice under a different payee number?*

A: Any core services provided to one of your practice's registered patients will result in a service outflow, and the fee-for-service payment will be deducted from the population-based funding that your practice receives.

Q: *What happens if our practice hires a locum?*

A: Compensation for locum services is negotiated between the locum and the practice/contractor. It is the practice's choice whether the locum works under the practice's payee number, or their own payee number (or a payee number other than the one belonging to the practice). If the locum is working under your practice's payee number, then the same funding and patient registration policies apply to the locum as to the other physicians in your practice.

Q: *If we have a locum who wishes to work under his/her own payee number (or a payee number that does not belong to our practice), how does this affect the population-based funding that our practice receives?*

A: The locum will bill fee-for-service for the care they provide to patients. When the locum bills fee-for-service for any core service(s) s/he provided to your practice's registered patients, then the fee-for-service payment(s) will be treated as a service outflow. These payments will then be deducted from the population-based funding that your practice receives.

To avoid service outflows, you can register the locum's practitioner number to your practice's MSP payee number. Please note that if a locum is using your practice's payee number, s/he cannot bill fee-for-service for any core services provided to a registered patient.

Q: *What happens if we provide services to a patient who has been referred to the practice for prenatal care by her family physician, but will be returning to her family physician after delivery?*

Physicians will receive the following benefits and other commitments:

1) **Northern Isolation Allowance (NIA)**
For those eligible, NIA will be provided at the same rate as that for qualifying fee-for-service physicians.

The NIA payment will be calculated for practices using the NIA rate for the community in which the primary care practice is located. NIA payments will be calculated based on the practice's population-based funding and fee-for-service payments

2) **On-Call Emergency Coverage Program**
In communities that are eligible for the Northern Isolation Allowance and have a hospital, the primary care practice will receive funding under the Emergency Coverage Program

3) **Physician Benefits (Continuing Medical Education, Physician Disability Insurance and Canadian Medical protective Association)**

Physicians can obtain these benefits either through the BCMA or as part of its PCDP contractual benefits (but not both).

4) **Physician Benefits (Contributory Professional Retirement Savings Plan)**

Contributory Professional Retirement Savings Plan will not be provided as part of the practice funding, but physicians will be eligible to participate under the program administered by the BCMA.

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To register a locum's practitioner number to the practice's payee number, submit an "Assignment of Payment" form to MSP Provider Programs (contact Provider Programs through the Teleplan Helpdesk at 1-800-663-7206).

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Q: *What happens if we provide services to a patient who has been referred to the practice for prenatal care by her family physician, but will be returning to her family physician after delivery?*

See section on Data Submission for information on how to submit a claim so that the fee-for-service payment is not reduced by 50%.

A: The practice will bill fee-for-service for any core services provided, and the third and any subsequent fee-for-service claim for core services will *not* be reduced by 50%.

Q: *What happens when I am acting as doctor of the day at a hospital?*

A: "Doctor of the day patients" are patients that a physician admits and treats while acting as doctor of the day at a hospital. Doctor of the day patients either (1) do not have a GP with hospital privileges, or (2) their GP does have hospital privileges, but is unavailable to provide care. For these patients, your practice will bill fee-for-service for any core services you provided, and the third and any subsequent fee-for-service claim for core services will *not* be reduced by 50%.

Q: *What strategies has the research literature (or other jurisdictions) found to reduce patient multi-doctoring?*

A: The following have been identified as key:

- Extended hours of service
- Choice of visiting a practitioner other than a physician if a physician's expertise is not required
- Access to care providers specializing in nutrition, weight loss, and preventive care
- Availability of on-call or telephone services for medical advice after hours
- Educating patients on the importance of choosing one family practice, and receiving their care from that one practice.

Direct Patient Billing

1. *Services eligible for direct billing include:*

Non-Medically Required Services
- Cosmetic surgery
- Routine circumcision of newborn
- Varicose vein treatment for cosmetic reasons
- Tattoo removal
- Acupuncture

Medical Legal Services
- Letters to lawyers
- Letters for any purpose other than medical necessity
- Employment
- Statement of health
- Certification of treatment/attendance

Completion of Forms
- Time loss benefits
- ICBC and other insurance forms
- Government agency, school or tax forms
- Transfer of medical records

Examination for Purposes Other than Treatment of Illness or Medical Symptoms
- Private adoptions
- Employment
- Insurance
- Motor vehicle or pilot license
- Physical fitness activity
- School or university requirements
- Sports
- Summer camps
- Travel fitness

2. *Services NOT eligible for direct billing include:*

- Preventative medicine counseling
- Medical advice by telephone or letter
- Annual or periodic medical checkup where no disease or symptoms are present
- Eye examinations

Suggestions on Practice Internal Income Allocation

Population-based funding is calculated based on a group practice's registered patient caseload. Once calculated, this income is then allocated to the practice as a lump sum payment, as opposed to individual payments made to each of the practice's physicians.

Income Allocation Strategies to Avoid

First of all, the practice should keep in mind the reasons why it chose to move to a population-based funding method. This will automatically lead you to forego the idea of allocating the funding among physicians based on the number of services each physician provided to the practice's registered patients. While an internal fee-for-service system is easy to implement (and a familiar way doing things), it is counterproductive to why the choice was made to move to a funding system that is not based on the volume of services provided.

Second, while it may be intuitively appealing to assign a certain number/group of the practice's registered patients to a particular physician (and thus allocate the income generated by the cluster of patients to the particular physician), this method will probably not result in an equitable allocation of funding because physicians in a group practice share responsibility for the care of the practice's entire patient caseload.

It is also possible that a particular physician may end up having too many patients to care for, or too large a share of patients with the more complex medical problems. This will result in the other members of the group having to assist in the care of the patients on that physician's list – this in turn, may require the development of additional internal funding strategies in order to pay the other physicians for taking care of one's patients. As well, this approach could limit flexibility for physicians who want to reduce their office time for whatever reasons.

Income Allocation Strategies to Consider

In general, it is recommended that the practice allocate the population-based funding using either a salary or sessional arrangement (or some combination of the two).

A salary arrangement tends be a fair and reasonable method of funding allocation only if each physician works the same hours, and is seen as equal in experience, skills, etc.

Most physicians currently keep regular clinic hours. Thus, it is possible to divide the physicians' regularly scheduled time in the clinic into sessions (for example 3.5 hour blocks), or clinic hours per week.

A: The practice will bill fee-for-service for any core services provided, and the third and any subsequent fee-for-service claim for core services will *not* be reduced by 50%.

See section on Data Submission for information on how to submit a claim so that the fee-for-service payment is not reduced by 50%.

Q: *What happens when I am acting as doctor of the day at a hospital?*

A: "Doctor of the day patients" are patients that a physician admits and treats while acting as doctor of the day at a hospital. Doctor of the day patients either (1) do not have a GP with hospital privileges, or (2) their GP does have hospital privileges, but is unavailable to provide care. For these patients, your practice will bill fee-for-service for any core services you provided, and the third and any subsequent fee-for-service claim for core services will *not* be reduced by 50%.

Q: *What strategies has the research literature (or other jurisdictions) found to reduce patient multi-doctoring?*

A: The following have been identified as key:

- Extended hours of service
- Choice of visiting a practitioner other than a physician if a physician's expertise is not required
- Access to care providers specializing in nutrition, weight loss, and preventive care
- Availability of on-call or telephone services for medical advice after hours
- Educating patients on the importance of choosing one family practice, and receiving their care from that one practice.

Direct Patient Billing

1. *Services eligible for direct billing include:*

Non-Medically Required Services
- Cosmetic surgery
- Routine circumcision of newborn
- Varicose vein treatment for cosmetic reasons
- Tattoo removal
- Acupuncture

Medical Legal Services
- Letters to lawyers
- Letters for any purpose other than medical necessity
- Employment
- Statement of health
- Certification of treatment/attendance

Completion of Forms
- Time loss benefits
- ICBC and other insurance forms
- Government agency, school or tax forms
- Transfer of medical records

Examination for Purposes Other than Treatment of Illness or Medical Symptoms
- Private adoptions
- Employment
- Insurance
- Motor vehicle or pilot license
- Physical fitness activity
- School or university requirements
- Sports
- Summer camps
- Travel fitness

2. *Services NOT eligible for direct billing include:*

- Preventative medicine counseling
- Medical advice by telephone or letter
- Annual or periodic medical checkup where no disease or symptoms are present
- Eye examinations

Suggestions on Practice Internal Income Allocation

Population-based funding is calculated based on a group practice's registered patient caseload. Once calculated, this income is then allocated to the practice as a lump sum payment, as opposed to individual payments made to each of the practice's physicians.

For most practices, population-based funding makes up about 70% of a practice's total income, with other income sources being Medical Services Plan fee-for-service billings, third party billings (ICBC and WCB), and direct patient charges.

An important (and sometimes difficult) decision that the practice must make is how to divide the population-based funding among each of the physicians. The following are suggestions that you might find useful in developing a way to allocate the practice income. Please remember that there is no perfect system that will be perfect forever—it will always require fine tuning along the way.

Income Allocation Strategies to Avoid

First of all, the practice should keep in mind the reasons why it chose to move to a population-based funding method. This will automatically lead you to forego the idea of allocating the funding among physicians based on the number of services each physician provided to the practice's registered patients. While an internal fee-for-service system is easy to implement (and a familiar way doing things), it is counterproductive to why the choice was made to move to a funding system that is not based on the volume of services provided.

Second, while it may be intuitively appealing to assign a certain number/group of the practice's registered patients to a particular physician (and thus allocate the income generated by the cluster of patients to the particular physician), this method will probably not result in an equitable allocation of funding because physicians in a group practice share responsibility for the care of the practice's entire patient caseload.

It is also possible that a particular physician may end up having too many patients to care for, or too large a share of patients with the more complex medical problems. This will result in the other members of the group having to assist in the care of the patients on that physician's list – this in turn, may require the development of additional internal funding strategies in order to pay the other physicians for taking care of one's patients. As well, this approach could limit flexibility for physicians who want to reduce their office time for whatever reasons.

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In general, it is recommended that the practice allocate the population-based funding using either a salary or sessional arrangement (or some combination of the two).

A salary arrangement tends be a fair and reasonable method of funding allocation only if each physician works the same hours, and is seen as equal in experience, skills, etc.

Most physicians currently keep regular clinic hours. Thus, it is possible to divide the physicians' regularly scheduled time in the clinic into sessions (for example 3.5 hour blocks), or clinic hours per week.

The practice may also want to budget for locums, if it is felt that this is preferable to scheduling time-off among physicians in a way that ensures adequate coverage.

Reminder: when calculating the total net income, the practice should determine at the outset how many allied health care providers will be funded out of the income generated by the practice.

In general, sessional payment allows for more flexibility in the time that each physician spends doing clinical work for the group practice. If desired, a portion of the practice's total income (e.g., 30%) might be used as reward/incentive payments for activities that the practice undertakes to provide comprehensive, quality primary care.

Some examples of the types of activities for which you many want to consider providing reward/incentive payments are:

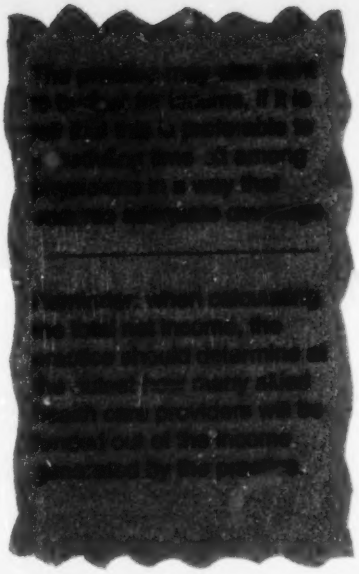
- Out-of-hours work (e.g., on-call);
- Taking part in case conferences;
- Undertaking administrative work, teaching, supervision of health care team members, etc;
- Any specialized training that a physician brings to the practice, or willingness to provide procedures that the other physicians would prefer not to undertake;
- Undertaking additional work not directly connected to the practice (e.g., occupational medical for a company);
- Number of years with the practice;
- Number of patients that have become registered with the practice as a result of information provided by the physician;
- Flexibility in the number of days/weeks worked per year;
- Continuing Medical Education, other benefits (e.g., Canadian Medical Protective Association, Contributory Professional Retirement Savings Plan), and holidays;
- Other activities that would improve how your practice provides primary health care.

If you wish to include rewards/incentive payments, then you will need to decide what percentage of your practice's total population-based net income you want to allocate for sessional/salary payments, and how much to allocate for reward/incentive payments.

A "Basic" Sessional Internal Payment Method to Consider

Step 1: Calculate the *total net* income generated by the practice (this includes the population-based funding, and if desired could also include 3rd party billings and any fee-for-service billings).

- Each practice should decide on how to handle other sources of practice income (e.g., 3rd party billings, occupational medicine work). You might wish to make this part of the practice net income and be paid at a sessional rate - alternatively, you might want to consider it an outside activity that is not part of the practice income.



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Step 2: The length of a session will need to be determined, but typically is three hours long plus an additional 30 minutes for phone or lab results review. At maximum, a physician should work only two 2 sessions per day (but one of these sessions might be into the evening hours).

You may want to consider the following scheduling suggestions:

- Have appointment slots accommodating 4–5 patients per hour, allocating one or more of these slots to patients with the more complex medical problems; and/or;
- Hold 1 appointment slot per hour open to accommodate patients who do not have an appointment.

Step 3: Allocate 70% of the practice's total net income to pay for the sessional work. To do this:

Step 4: Determine number of weekly and holiday days-off. After this is done, for the remaining workdays determine how many sessions each physician expects to work over the 12 months (e.g., 8 sessions per week). Finally, add these up to get the total number of sessions the physicians expect to work.

To determine your practice's sessional rate, take the total practice funding you have allocated to pay for the sessional work, and divide it by the total number of sessions that the physicians expect to work.

Building in reward/incentive payments

Step 5: The remaining 30% of the practice's total net income would be used for reward/incentive payments. Your practice will need to consider: (a) which activities you want to allocate reward/incentive payments towards; (b) the amount of funding that would be allocated toward each activity, and (c) how you would actually allocate funds. For example, you may want to:

- Pay for procedures done (or assisted) out of hours (e.g., attendance at deliveries, house calls); attending at the emergency room; for completion of insurance forms/letters, etc.
- Use 15% of the practice's net income for holiday and Continuing Medical Education time. For example, you might want to provide one session of paid time-off for every 5 sessions worked.
- You may want to consider paying 2 sessions for a night on-call. This would enable the physician take the next day off without incurring a loss in income.

The above income allocation strategy should work out to the current average cash flows. The above can be adjusted as needed to make them fit within your budget parameters.

Step 6: Draw up a payment schedule (e.g., every week, monthly, etc).

With respect to allocating the funding that was set aside for reward/ incentive payments (e.g., approximately 30% of the total income generated), you may want to wait and allocate some (approximately, 5% to 10%) of these funds at the end of the fiscal year (and perhaps even base them on profit/surpluses) in order to cover any un-anticipated shortfalls.

Creating a Patient Register

In order to calculate the practice's population-based funding, the population of patients who receive the majority of their primary care from the practice must be identified (these patients are known as "registered patients"). This is done by reviewing the Medical Service Plan claims data from the previous three years to identify patients who receive the majority of their "core" primary care services from the practice.

The following describes how this review is done, and how the primary care practice and Ministry of Health work together to identify the practice's registered patients.

Step 1: Identify patients who are eligible for patient registration

In order to be a registered patient, the patient must:

i) be a Canadian citizen or lawfully admitted to Canada for permanent residence (exception: foreign student);

ii) make his/her home in British Columbia;

iii) be resident in British Columbia at least 6 months in a calendar year;

iv) possess a British Columbia Medical Service Plan personal health number; and

v) be enrolled with the Medical Services Plan.

Step 2: Construct an initial list of patients

This initial patient list consists of all eligible patients who received at least one core service from the practice in the past 3 years.

Three years is a long enough period of time to identify all the patients who receive their primary care from a particular practice. However, a small number of patients may be missed simply because they have been healthy during this time period. If any patients are missed (for whatever reason), they can be added to the patient register.

Step 3: Remove all patients who do not live in the practice's catchment area from the initial patient list.

The practice's catchment area consists of the Local Health Area (a geographic subdivision of the province) in which the practice is located, and any adjacent Local Health Area from which a patient can reasonably be expected to use the practice as their main source of primary care.

The practice's catchment area is identified, and the patients on the initial patient list are divided into two categories. Patients who live in the catchment area, and patients who live outside it.

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The main source of income generation will be the extent to which you can increase the number of patients registered with your practice. The main factor drawing on the practice income will be the number of sessions each physician wants to work, and whether you will need locums or additional physicians to help carry the workload.

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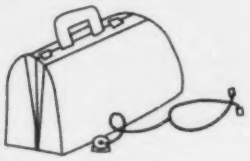
The practice's catchment area is identified, and the patients on the initial patient list are divided into two categories. Patients who live in the catchment area, and patients who live outside it.

Core primary care services **are services that all GPs are expected to provide in the delivery of comprehensive primary care, and are used in calculating the practice's population-based funding for the registered patients. Any other services not included in this group of "core" services (including anaesthesia, obstetric, and emergency services) remain fee-for-service. Core and non-core services provided to non-registered and transient patients remain fee-for-service. For more information, see section on *Practice Funding*.**



Patients who live outside the practice's catchment area, but on occasion receive medical care from the practice are known as "transient patients". Payment for services to transient patients will remain fee-for-service. Thus, transient patients are removed from the initial patient list.

Step 4: Remove patients who live inside the practice's catchment area but do not use the practice as their main source of primary care from the initial patient list

Two methods are used to establish whether a patient living in the practice's catchment area is using the practice as their main source of primary care:

- *Method 1*
  Identification of consecutive services received from the practice:

If the patient received their last two consecutive services from the practice, then s/he remains on the initial patient list.

If the patient received three consecutive services outside the practice, then s/he is removed from the initial patient list because it is likely that they do not receive the majority of their primary care from the practice. These patients are known as nonregistered patients.

Method 1 will not result in the classification of all patients because some patients will not have received two consecutive services from the practice, but nonetheless receive the majority of their primary care from the practice. On the other hand, some patients may have received three consecutive services outside the practice yet still receive the majority of their primary care from the practice.

As such, Method 2 is used to classify these remaining patients.

- *Method 2*
  Percentage of services received from the practice:

The percentage of services provided to a patient by the practice is used to determine whether the patient should be removed from the initial patient list.

Patients who receive 0%-50% of their last seven core services from the practice are removed from the patient list. These patients are considered nonregistered patients.

Patients who receive the majority of their primary care from the practice (that is, >50% of their last seven core services), remain on the patient list.

Rationale for Consecutive Service Criteria: Patients in BC receive an average of seven GP services a year. (In 1996/97 the average number of GP services per patient was 7.22 [23.198 million services for 3.212 million patients] – Source: *BC Ministry of Health statistics*)

If a patient has seen the same physician for their last two visits, then it is likely that they are using the same practice for the majority of their primary care. Similarly, a patient who receives their last three consecutive services elsewhere, is probably no longer using the practice as their main source of primary care.

A patient can be registered with only one practice at any given time. The practice should inform patients that they are registered patients. This should include notification that the practice's funding is not based upon the number of services provided.

Patients should be asked to notify the practice if they are moving and will no longer be receiving their primary care from the practice.

Patients must also be informed that, in accordance with the Canada Health Act, they are free to access medical services outside of the practice or change their family physician at any time.

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As such, Method 2 is used to classify these remaining patients.

- *Method 2*
  Percentage of services received from the practice:

The percentage of services provided to a patient by the practice is used to determine whether the patient should be removed from the initial patient list.

Patients who receive 0%-50% of their last seven core services from the practice are removed from the patient list. These patients are considered nonregistered patients.

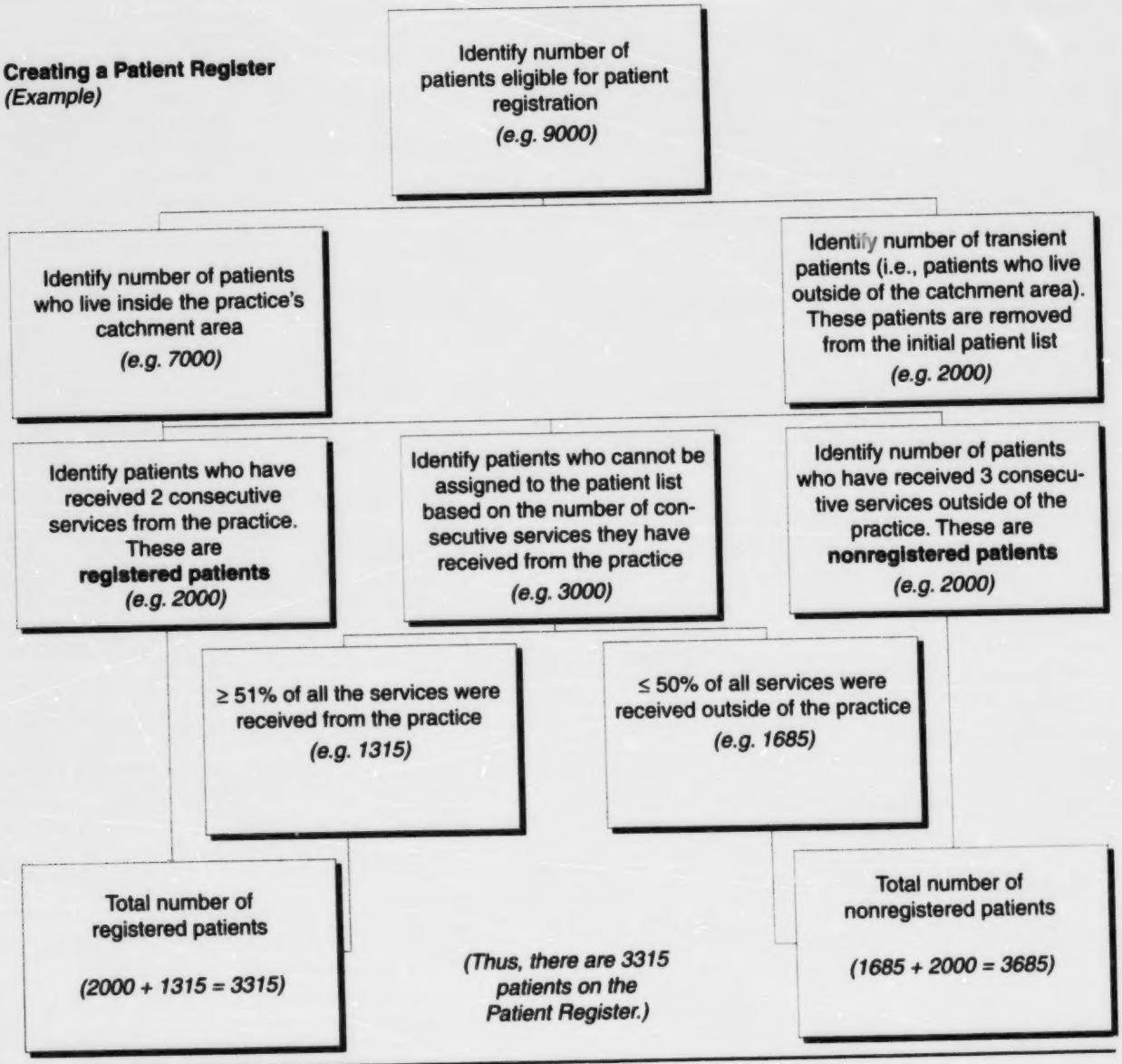
Patients who receive the majority of their primary care from the practice (that is, >50% of their last seven core services), remain on the patient list.

Step 5: Establish the Practice's Patient Register

The Ministry will provide the patient list (compiled via Steps 1 through 3) to the practice. The list will have the patients categorized as being transient, nonregistered, or registered patients. The practice will then review the patient list and advise the Ministry of patients who are classified incorrectly. The final list of patients that results from the practice's review will comprise the practice's patient register.

The patient register is used to calculate the amount of population-based funding the practice receives. Therefore, in order to ensure that the funding received accurately reflects the patient population, it is important to keep the patient register up-to-date. Practices can add or remove patients from their patient register at any time (See Updating the Practices Register section).

Creating a Patient Register
(Example)


Identify number of patients eligible for patient registration
(e.g. 9000)
Identify number of patients who live inside the practice's catchment area
(e.g. 7000)
Identify number of transient patients (i.e., patients who live outside of the catchment area). These patients are removed from the initial patient list
(e.g. 2000)
Identify patients who have received 2 consecutive services from the practice. These are registered patients
(e.g. 2000)
Identify patients who cannot be assigned to the patient list based on the number of consecutive services they have received from the practice
(e.g. 3000)
Identify number of patients who have received 3 consecutive services outside of the practice. These are nonregistered patients
(e.g. 2000)
≥ 51% of all the services were received from the practice
(e.g. 1315)
≤ 50% of all services were received outside of the practice
(e.g. 1685)
Total number of registered patients
(2000 + 1315 = 3315)
(Thus, there are 3315 patients on the Patient Register.)
Total number of nonregistered patients
(1685 + 2000 = 3685)

Updating the Practice's Patient Register

The population-based funding that a primary care practice receives is calculated based on the number of patients registered with the practice as opposed to the number of services provided. Therefore, it is important to ensure that your practice's patient register is kept up-to-date.

Q: When can I register a patient?

A: You can register a patient anytime. However, if the patient received any core services from the practice during the quarter, then their effective date of registration will be backdated to the date that the first core service was received. Any fee-for-service payments made to the practice for core services will be deducted from the population-based funding.

Q: How do I add a patient to the practice's patient register?

A: You have two options.

1) You can submit a patient registration record using a modified Teleplan system. In order for the patient registration record to be accepted by Teleplan, the patient must live in the catchment area, and have received at least one service from the practice in the last three months; or

2) If the patient does not meet the above criteria, you can call the Teleplan Helpdesk (1-800-663-7206) and ask that they manually register the patient with your practice.

Q: Can I remove a patient from the practice's patient register? How do I do this?

A: Yes. You can deregister a patient either by:

1) submitting a patient deregistration record via your *modified* Teleplan system, or
2) by calling the Teleplan Helpdesk (1-800-663-7206) and ask that they update your patient register.

Please note that a patient cannot be deregistered solely on the basis of their health status. Any request for patient deregistration based on health status will be reviewed by the Ministry of Health for decision.

Q: Each quarter the Ministry of Health will identify patients who should be added or removed from the patient register. Under what circumstances can I ask that a proposed change not occur?

A: The table below summarizes the circumstances under which the Ministry of Health will propose that a patient be registered or deregistered from your practice. The table also summarizes the circumstances under which you can request that the Ministry not make the proposed changes.

Table 1. Reasons for Proposing Patient Registration and Deregistration (*See also: page 24*)

Ministry will propose that a patient be automatically added to the patient register when:	Valid Reason (and reason codes in brackets) for requesting that the Ministry not automatically add a patient to the patient register:
1. the patient has received his/her last two (2) consecutive services from your practice ('01'); 2. fifty-one (51) percent or greater of the patient's services were obtained from your practice within a six month period ('02'); 3. the patient was registered through PCDP practice/MSP register synchronization process ('03'); 4. the patient is registered to your practice, but their registration effective date is being backdated ('M') Reason codes for proposing change are denoted in brackets	('C') a practice physician was covering for a vacationing physician ('D') the patient is deceased ('F') the practice is full and not accepting new patients ('I') the patient expressed his/her intent to see another general practitioner outside of your practice ('M') the patient has moved ('N') the patient is not known to your practice ('R') the patient has been referred to another general practitioner outside of your practice ('T') the patient is/was being seen as a temporary patient referral from another general practitioner outside of your practice ('V') the patient is/was visiting the catchment area ('A') Another reason – must send an accompanying Teleplan "note record" describing the reason.
Ministry will propose that a patient be automatically removed from the patient register when:	Valid Reason (and reason code in brackets) for requesting that the Ministry not automatically remove a patient from the patient register:
1. a patient's last three (3) consecutive services were obtained outside of your practice ('C'); 2. a patient has received two services, but not from your practice ('B1'); 3. a patient has received more than two services, of which fifty-one (51) percent or greater were received from a physician(s) outside of your practice ('D'); 4. a patient is deceased ('A01'); 5. a patient now resides outside of the practice catchment area ('B'); 6. a patient has received five core services from outside your practice during the past 6 months ('F'); 7. a patient no longer has MSP coverage ('A'); 8. a patient has two (2) or more services outside catchment area ('X1'); 9. a patient's last two (2) services were outside the catchment area ('X2')	('C') the patient saw another general practitioner while their usual general practitioner was on vacation ('E') Ministry records are incorrect, and the patient has MSP coverage ('I') the patient lives outside the catchment area, but works or attends school in the catchment area ('S') the patient lives outside the catchment area, but requires special care available at your practice ('T') the patient was temporarily referred to another practitioner for a special condition ('U') the Ministry address for the patient is incorrect, and the patient lives in the catchment area. Regardless of whether you notify the Ministry of Health using your software or by telephone, ensure that you supply a valid reason code (denoted in brackets).

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Please note that a patient cannot be deregistered solely on the basis of their health status. Any request for patient deregistration based on health status will be reviewed by the Ministry of Health for decision.

Q: *Each quarter the Ministry of Health will identify patients who should be added or removed from the patient register. Under what circumstances can I ask that a proposed change not occur?*

A: The table below summarizes the circumstances under which the Ministry of Health will propose that a patient be registered or deregistered from your practice. The table also summarizes the circumstances under which you can request that the Ministry not make the proposed changes.

The Quarterly Review Process

To assist the practice in ensuring that the patient register is up-to-date, the Ministry of Health will review service utilization claims data on a quarterly basis to identify patients who should be added or removed from the patient register. Reasons for why patient registration or deregistration is proposed are shown in Table 1.

The Teleplan System will require modifications by your vendor. The MSP Teleplan/PC Record Specifications Version 3 is available by contacting the Ministry of Health at 1-800-663-7206.

Table 1. Reasons for Proposing Patient Registration and Deregistration (*See also: page 24*)

Ministry will propose that a patient be automatically added to the patient register when:	Valid Reason (and reason codes in brackets) for requesting that the Ministry not automatically add a patient to the patient register:
1. the patient has received his/her last two (2) consecutive services from your practice ('01'); 2. fifty-one (51) percent or greater of the patient's services were obtained from your practice within a six month period ('02'); 3. the patient was registered through PCDP practice/MSP register synchronization process ('03'); 4. the patient is registered to your practice, but their registration effective date is being backdated ('M') Reason codes for proposing change are denoted in brackets	('C') a practice physician was covering for a vacationing physician ('D') the patient is deceased ('F') the practice is full and not accepting new patients ('I') the patient expressed his/her intent to see another general practitioner outside of your practice ('M') the patient has moved ('N') the patient is not known to your practice ('R') the patient has been referred to another general practitioner outside of your practice ('T') the patient is/was being seen as a temporary patient referral from another general practitioner outside of your practice ('V') the patient is/was visiting the catchment area ('A') Another reason – must send an accompanying Teleplan "note record" describing the reason.

Ministry will propose that a patient be automatically removed from the patient register when:	Valid Reason (and reason code in brackets) for requesting that the Ministry not automatically remove a patient from the patient register:
1. a patient's last three (3) consecutive services were obtained outside of your practice ('C'); 2. a patient has received two services, but not from your practice ('B1'); 3. a patient has received more than two services, of which fifty-one (51) percent or greater were received from a physician(s) outside of your practice ('D'); 4. a patient is deceased ('A01'); 5. a patient now resides outside of the practice catchment area ('B'); 6. a patient has received five core services from outside your practice during the past 6 months ('F'); 7. a patient no longer has MSP coverage ('A'); 8. a patient has two (2) or more services outside catchment area ('X1'); 9. a patient's last two (2) services were outside the catchment area ('X2')	('C') the patient saw another general practitioner while their usual general practitioner was on vacation ('E') Ministry records are incorrect, and the patient has MSP coverage ('I') the patient lives outside the catchment area, but works or attends school in the catchment area ('S') the patient lives outside the catchment area, but requires special care available at your practice ('T') the patient was temporarily referred to another practitioner for a special condition ('U') the Ministry address for the patient is incorrect, and the patient lives in the catchment area. Regardless of whether you notify the Ministry of Health using your software or by telephone, ensure that you supply a valid reason code (denoted in brackets).

Please note that if you register or deregister patients by phoning the Teleplan Helpdesk, you should ensure that you use your modified Teleplan system to update the patient registration and deregistration dates stored in your copy of the patient register.

Q: *What should I do if I do not agree with the Ministry of Health's proposed changes to my patient register, and do not want a change made?*

A: Within the 14 days of receiving the list of changes, you should notify the Ministry of the patient(s) you do not want registered or deregistered, and why (valid reasons for requesting that a change not be made are shown in Table 1. *See pages 15 or 24*).

You can notify the Ministry either by:

(1) submitting a "registration override" record (to prevent a patient's registration) or a "deregistration override" record (to prevent a patient's deregistration) via your modified Teleplan system, or

(2) you can phone the Teleplan Helpdesk (1-800-663-7206) and request that the change not be made

If you do not contact the Ministry regarding your registration "overrides" within 14 days after receiving the list, then the proposed changes to your patient register will be made. The register will be updated as of the 1st day of the upcoming quarter.

The updated patient register will then be used to calculate your population-based funding for the upcoming quarter.

Q: *What should I do if I agree with the Ministry of Health's proposed changes to my patient register?*

A: You do not have to notify the Ministry of Health that you agree with the proposed changes to the patient register. However, to ensure that your practice's patient register is fully up-to-date, you should use your modified Teleplan system to update the patient registration and deregistration dates stored in your copy of the patient register.

Q: *How will I be informed that the Ministry is proposing adding or removing patients from the register as a result of the quarterly review?*

A: A list of patients who appear as though they should be registered, or deregistered from the practice will be sent to your Teleplan mailbox as a "MO1 Message". Reason codes for the proposed change are shown in Table 1.

Q: *When do the changes in patient registration and deregistration status come into effect?*

A: This depends on whether the change in patient registration status was made by the practice or whether it resulted from the Ministry's quarterly review of patient registration status. (*See Table 2.*)

Table 2. When Patient Register Changes Come into Effect

REGISTRATION	DEREGISTRATION
If the patient is registered by your practice then: The effective date of registration will be set to the "registration effective date" you provided in the registration record submitted via Teleplan.	If the patient is deregistered by your practice then: The effective date of deregistration will be set to the "deregistration effective date" you provided in the deregistration record you submitted via Teleplan.
If the patient is registered with your practice as a result of the Ministry quarterly review, The effective date of registration will be set as the first day of the next quarter, except in the following case: 1. If your practice has submitted one or more fee-for-service claim(s) for the patient during the quarter (and if the patient has not received any services from outside your practice during this time), then the registration date will be back-dated to the date during the quarter at which time the first core service was provided to the patient. Any fee-for-service payments made for core services will then be deducted from the population-based funding the practice receives for that patient. Please note that a registration date will never be backdated earlier than the first day of the *current* quarter.	If the patient is registered with your practice as a result of the Ministry quarterly review, the effective date of registration will be set as the last day of the current quarter under review, except in the following circumstances: 1. If the patient died prior to the end of the quarter, the date of deregistration would be the reported date of death 2. If the patient no longer has MSP coverage, the date of deregistration would be the last day the patient was covered by MSP.

Q: *Why is it important to correctly record the patient registration and deregistration dates?*

A: The payment rate that the practices receives for a patient is calculated based on the number of days that the patient is registered with the practice during each quarterly period. Essentially, the fewer the days the patient is registered, the less funding the practice receives for that patient.

Q: *Can I register a patient who does not live in the practice's catchment area?*

A: Yes. However, any core services that the patient receives from another practice inside your practice's catchment area, or from a practice located in the local health area in which the patient resides, will be a service outflow (this policy is under review).

Q: *What should I do if I do not agree with the Ministry of Health's proposed changes to my patient register, and do not want a change made?*

A: Within the 14 days of receiving the list of changes, you should notify the Ministry of the patient(s) you do not want registered or deregistered, and why (valid reasons for requesting that a change not be made are shown in Table 1. *See pages 15 or 24*).

You can notify the Ministry either by:

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A: You do not have to notify the Ministry of Health that you agree with the proposed changes to the patient register. However, to ensure that your practice's patient register is fully up-to-date, you should use your modified Teleplan system to update the patient registration and deregistration dates stored in your copy of the patient register.

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Q: *Why is it important to correctly record the patient registration and deregistration dates?*

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Q: *Can I register a patient who does not live in the practice's catchment area?*

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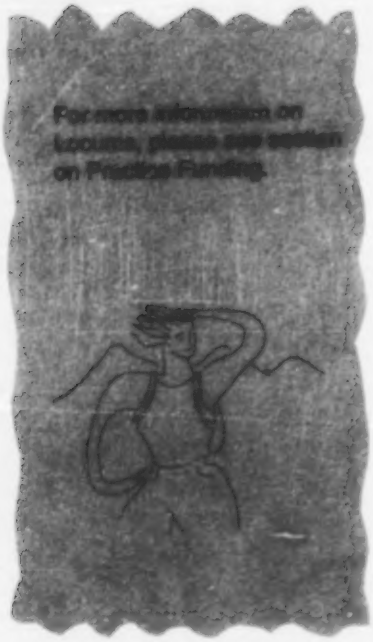

Q: *Can a patient be registered to a practitioner number belonging to a locum or nurse or other health care professional?*

A: No. When submitting a patient registration record, ensure that the record includes the practitioner number of one of the practice's physicians and the practice's payee number.

Q: *What happens if a locum uses the practice's payee number to bill fee-for-service for two or more consecutive core services they provided to nonregistered patients?*

A: During the quarterly review, the Ministry will propose that these patients become registered with the practice if they have met the registration criteria of having received his/her last two (2) consecutive core services from the practice. Please note that the quarterly review will not automatically register patients with the practice if the locum uses his/her own payee number or a payee number that does not belong to the practice.

If the locum is using the practice's payee number, and provides more than two consecutive core services to a nonregistered patient, the fee-for-service payment for the third and any subsequent core services provided will be reduced by 50%. The practice should, therefore, consider registering the patient.

Data Submission

Patient Encounter Records and Fee-For-Service Claims

Blended funding uses both a population-based funding and fee-for-service component. This requires the submission of two kinds of data records to the Ministry of Health:

(1) a fee-for-service claim which is used to issue a fee-for-service payment; and
(2) a $0 patient encounter record which is used in re-calculating the population-based funding that a practice receives, and for the evaluation of the Primary Care Demonstration Project.

The format of the fee-for-service claim and the patient encounter record follows Teleplan's standard CO2 Claim Detail record format. As shown in Table 3, some fields in the record have been expanded beyond the standard fee-for-service claim record.

Table 3. Information required for submission of Patient Encounter Record and Fee-for-Service Claims (* is exception to FFS claim submission)

1. Payee Number	• The practice will be assigned a new payee number, that should be used instead of individual payee numbers. • Payee Status Type (Status 'F') allows the practice to submit both fee-for-service claims and patient encounter records.
2. B.C. Personal Health Number (PHN)	• Alberta Health Number should be used if care was provided to an Alberta resident while they were visiting BC.
3. Date and Time of Service(s)	• *Time of service is only required on a patient encounter record. It could be the patient's appointment time, the time that the patient arrived at the practice, or the time that the care provider began or ended delivering patient care. The time of service can be rounded to the nearest hour (14:00) if this is preferable to recording the actual time (14:15).
4. Practitioner Number	• Physicians will continue to use their existing practitioner number • The following specialty codes have been developed for other practitioners working on the health care team. Specialty codes will be assigned to practitioners who do not already have one. '81' Registered Nurse '82' Nutritionist/Dietician '83' Counsellor '84' Educator '85' Licensed Practical Nurse '86' Medical Office Assistant '87' Nurse Practitioner '88' Respiratory Therapist '89' Home Support '91' Pharmacist
5. Service/Procedure Provided	• Consists of the fee-for-service codes defined in the Medical Services Commission's Fee-For-Service Payment Schedule; and • * 63 additional PCDP extended service item codes have been developed for patient encounter records to capture project evaluation information on expanded role of health care providers in a team environment. • Fee-for-service claims cannot, under any circumstances, be submitted for extended service item codes.
6. ICD-9 Code	• Practices can now record up to 3 ICD-9 codes for each patient encounter. Only the first ICD-9 code is required. • Reporting the ICD-9 code to the 3rd digit is required. Reporting ICD-9 codes to the 4th or 5th digit is optional.
7. Facility Identifier	• Identifies location of where the service was provided in cases where the practice provides services in more than one clinic location.
8. Service Location	Represents location where a practitioner provided the service(s) to the patient: 'R' Patient's Residence 'O' Physician's Office 'C' Continuing Care Facility 'E' Hospital Emergency Department or Diagnostic & Treatment Centre 'S' Community Location (e.g., school, church hall or other temporary locations) 'D' Diagnostic Facility 'P' Outpatient 'H' Hospital 'I' Hospital Inpatient
9. Referral Identifier	If the practice refers a registered patient to another PCDP practice, the Practitioner Number of the referring physician should be reported. In most cases, referrals will be treated as service outflows.

Q: *Can a patient be registered to a practitioner number belonging to a locum or nurse or other health care professional?*

A: No. When submitting a patient registration record, ensure that the record includes the practitioner number of one of the practice's physicians and the practice's payee number.

For more information on Locums, please see section on Practice Funding.

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6. ICD-9 Code	• Practices can now record up to 3 ICD-9 codes for each patient encounter. Only the first ICD-9 code is required. • Reporting the ICD-9 code to the 3rd digit is required. Reporting ICD-9 codes to the 4th or 5th digit is optional.
7. Facility Identifier	• Identifies location of where the service was provided in cases where the practice provides services in more than one clinic location.
8. Service Location	Represents location where a practitioner provided the service(s) to the patient: 'R' Patient's Residence 'O' Physician's Office 'C' Continuing Care Facility 'E' Hospital Emergency Department or Diagnostic & Treatment Centre 'S' Community Location (e.g., school, church hall or other temporary locations) 'D' Diagnostic Facility 'P' Outpatient 'H' Hospital 'I' Hospital Inpatient
9. Referral Identifier	If the practice refers a registered patient to another PCDP practice, the Practitioner Number of the referring physician should be reported. In most cases, referrals will be treated as service outflows.

The information contained in a fee-for-service claim and a patient encounter record is virtually the same. The difference rests in when the information is submitted as a $0 encounter record or as an FFS claim record (and in turn the type of payment issued). These differences are shown in Table 4.

Table 4

Type of Patient	TYPE OF SERVICES					
	Core Services		PCDP Extended Services		Non-Core Services	
	Type of record submitted	will be paid as	Type of record submitted	will be paid as	Type of record submitted	will be paid as
Registered	$0 Encounter Record	$0 Encounter Record	$0 Encounter Record	$0 Encounter	FFS Claim	FFS Claim
Nonregistered	FFS Claim	FFS Claim	$0 Encounter Record	$0 Encounter	FFS Claim	FFS Claim
Transient	FFS Claim	FFS Claim	$0 Encounter Record	$0 Encounter	FFS Claim	FFS Claim

Teleplan's standard C02 record has been modified so that more information can be captured on the patient encounter record.

One patient encounter record can now record information for up to ten patients who were seen during a single encounter (e.g., patients participating in group counselling or other group sessions).

More than one practitioner number can now be reported in a single patient encounter record in order to capture information on a team-based approach to primary care delivery.

Data Submission via Teleplan

All data is submitted electronically through the Teleplan system. In order to submit both fee-for-service claims and patient encounter records, the Teleplan system must be modified to include the Payment Mode value 'E' (which identifies all patient encounter records), and the Payee Status of 'F' which allows a practice to submit both fee-for-service claims and patient encounter records. Each practice has a payee number assigned to it, which will include the 'F' Status Code.

Key Data Submission Rules

1. Fee-for-service claims will *not* be accepted for services provided by non-physician providers, unless specifically authorized as per the Medical Services Plan Guidelines and the Medical Services Commission Payment Schedule.

2. All patient records submitted by non-physician providers will be paid as a $0 encounter record.

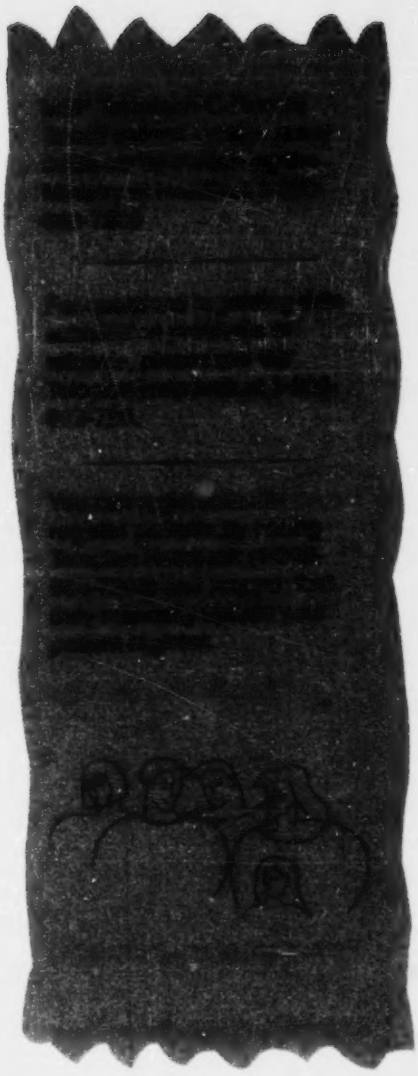
3. In order for a patient encounter record to be processed (i.e., not refused back to the practice for re-submission), it must be submitted using:

   - a Payee 'F' Status Code,
   - a Payment Mode of 'E",
   - the service/procedure item must be a core or an extended item with a $0 billed amount (please note that an encounter record will be rejected if it is submitted with an amount greater than $0 in the billed field),
   - the insurer must be MSP

4. In order for a fee-for-service claim to be processed, it must be submitted using:

   - the practice payee number
   - a Claim Payment Mode of '0' (zero), and
   - the insurer can be either MSP or a third party insurer (e.g., ICBC, WCB, OIN).

5. In order to maintain complete records for the project's evaluation, every practice health care team member should record and provide information on all patients seen, and all services provided to the patient. Locums or physicians providing on-call coverage to the practice under the practice's payee number should also provide information on all practice patients seen, and all services provided.



Patient Registration and Deregistration Records

The population-based funding that a primary care practice receives is calculated based on the practice's patient register. It is therefore important that the patient register be kept up-to-date (see section on Updating the Practice's Patient Register).

Updating the patient register can be done by submitting Patient Registration and Patient Deregistration records via the modified Teleplan system. The record format is the structured "Teleplan Note Record" (which accompanies the standard C02 claim record).

Key Data Submission Rules

1. Fee-for-service claims will *not* be accepted for services provided by non-physician providers, unless specifically authorized as per the Medical Services Plan Guidelines and the Medical Services Commission Payment Schedule.

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Updating the patient register can be done by submitting Patient Registration and Patient Deregistration records via the modified Teleplan system. The record format is the structured "Teleplan Note Record" (which accompanies the standard C02 claim record).

MSP Teleplan/PC Record Specifications Version 3 are available by contacting the Ministry of Health at 1-800-663-7206

For questions regarding data submission problems or refusals, please call the Teleplan Helpdesk at 1-800-663-720.

You can register or de-register patients by calling Teleplan Helpdesk (1-800-663-7206) and request that they manually update your patient register.

A Patient Registration Record *must* contain the following information or it will be returned to the practice for re-submission:

Patient Identifying Information	• Patient PHN and name verification code
Valid Physician Number	• Registration records submitted with a practitioner number *other* than a valid physician number will *not* be accepted, and will be returned to the practice for re-submission • The physician number of the physician "most responsible" for the patient should be used
Registration Effective Date	• The date when the practice decided to register the patient
Patient Address	• In order to be a "registered patient", the patient's postal code *must* be within the practice's catchment area. The postal code *must* be included in the address
Patient Administration Code	• This is used to indicate that a patient falls into a "special needs" funding category. The default value for this field is "O", and a special needs code will be assigned in consultation with the Ministry of Health

A "Registration Cancellation Date" can be supplied to the practice if a patient is temporarily living in the catchment area, and receiving their primary care from the practice for only the time-being (e.g., a university student registers with the practice for the school term, but will deregister during the summer months upon return home).

A Patient Deregistration Record *must* contain the following information or it will be returned to the practice for re-submission:

Patient Identifying Information	• A Patient PHN and name verification code
Registration Cancellation Date	• The date that the practice would like the patient deregistration to become effective
Registration Cancellation Reason Code	Valid reason codes are: 'D" Deceased 'S' Services are being received from a different practice 'L' Left the catchment area 'A' Another reason (requires inclusion of a short explanatory comment)

Patient Registration/Deregistration Changes Resulting from Ministry of Health's Quarterly Review

Each quarter the Ministry of Health will conduct a review of patient service utilization data, and identify patients who should be added or removed from the patient register based on the patient registration policies (see section on Updating the Practice's Patient Register).

A Teleplan "MO1 Message" record will be sent to your practice's Teleplan Mailbox in order to notify you of any pending patient registrations or deregistrations that resulted from the quarterly review. This "MO1 Message" record will include the following information:

Patient Identifying Information	• Patient PHN, gender, date of birth, full name, and address of file at Ministry of Health's Client Registry
Pending Registration Action Code	• 'R' denotes proposed patient registration • 'D' denotes proposed patient deregistration
Reason Code	• See Table 5 for valid reasons for proposing patient registration and deregistration
Registration or Deregistration Effective Dates	• Date the proposed registration or deregistration will become effective

"Overrriding" Proposed Patient Registration and Deregistration

Within the 14 days of receiving list of changes to patient register, you should notify the Ministry of any patient(s) you do not want registered or deregistered (and why). This is done by submitting a "registration override" record (to prevent a patient's registration) or a "deregistration override" record (to prevent a patient's deregistration) via you modified Teleplan system. The override record must include the reason why you do not want the change made. Valid reasons (and the associated codes) are shown in Table 5.

You can also call the Teleplan Helpdesk (1-800-663-7206) and request that the change in patient registration not be made. Please be sure to provide a valid reason code.

M121

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Table 5. Reasons for Proposing Patient Registration and Deregistration (*See also: page 15*)

Ministry will propose that a patient be automatically added to the patient register when:

1. the patient has received his/her last two (2) consecutive services from your practice ('01');
2. fifty-one (51) percent or greater of the patient's services were obtained from your practice within a six month period ('02');
3. the patient was registered through PCDP practice/MSP register synchronization process ('03');
4. the patient is registered to your practice, but their registration effective date is being backdated ('M')

Reason codes for proposing change are denoted in brackets

Valid Reason (and reason codes in brackets) for requesting that the Ministry not automatically add a patient to the patient register:

- ('C') a practice physician was covering for a vacationing physician
- ('D') the patient is deceased
- ('F') the practice is full and not accepting new patients
- ('I') the patient expressed his/her intent to see another general practitioner outside of your practice
- ('M') the patient has moved
- ('N') the patient is not known to your practice
- ('R') the patient has been referred to another general practitioner outside of your practice
- ('T') the patient is/was being seen as a temporary patient referral from another general practitioner outside of your practice
- ('V') the patient is/was visiting the catchment area
- ('A') Another reason – must send an accompanying Teleplan "note record" describing the reason.

Ministry will propose that a patient be automatically removed from the patient register when:

1. a patient's last three (3) consecutive services were obtained outside of your practice ('C');
2. a patient has received two services, but not from your practice ('B1');
3. a patient has received more than two services, of which fifty-one (51) percent or greater were received from a physician(s) outside of your practice ('D');
4. a patient is deceased ('A01');
5. a patient now resides outside of the practice catchment area ('B');
6. a patient has received five core services from outside your practice during the past 6 months ('F');
7. a patient no longer has MSP coverage ('A');
8. a patient has two (2) or more services outside catchment area ('X1');
9. a patient's last two (2) services were outside the catchment area ('X2')

Valid Reason (and reason code in brackets) for requesting that the Ministry not automatically remove a patient from the patient register:

- ('C') the patient saw another general practitioner while their usual practice/general practitioner was on vacation
- ('E') Ministry records are incorrect, and the patient has MSP coverage
- ('I') the patient lives outside the catchment area, but works or attends school in the catchment area
- ('S') the patient lives outside the catchment area, but requires special care available at your practice
- ('T') the patient was temporarily referred to another practitioner for a special condition
- ('U') the Ministry address for the patient is incorrect, and the patient lives in the catchment area.

Regardless of whether you notify the Ministry of Health using your software or by telephone, ensure that you supply a valid reason (denoted in brackets).

Please note: The most common errors made in submitting registration records are:

- 'P7' missing data such as incomplete address (data entry error), bad claim format (software error)
- 'W1' postal code is missing or wrong format was used
- 'P9' postal code is outside the practice catchment area, or the postal code is not recognized
- 'HV' the patient is already registered with the practice.

Table 5. Reasons for Proposing Patient Registration and Deregistration *(See also: page 15)*

Ministry will propose that a patient be automatically added to the patient register when:	Valid Reason (and reason codes in brackets) for requesting that the Ministry not automatically add a patient to the patient register:
1. the patient has received his/her last two (2) consecutive services from your practice ('01'); 2. fifty-one (51) percent or greater of the patient's services were obtained from your practice within a six month period ('02'); 3. the patient was registered through PCDP practice/MSP register synchronization process ('03'); 4. the patient is registered to your practice, but their registration effective date is being backdated ('M') Reason codes for proposing change are denoted in brackets	('C') a practice physician was covering for a vacationing physician ('D') the patient is deceased ('F') the practice is full and not accepting new patients ('I') the patient expressed his/her intent to see another general practitioner outside of your practice ('M') the patient has moved ('N') the patient is not known to your practice ('R') the patient has been referred to another general practitioner outside of your practice ('T') the patient is/was being seen as a temporary patient referral from another general practitioner outside of your practice ('V') the patient is/was visiting the catchment area ('X') Another reason – must send an accompanying Teleplan "note record" describing the reason.
Ministry will propose that a patient be automatically removed from the patient register when: 1. a patient's last three (3) consecutive services were obtained outside of your practice ('C'); 2. a patient has received two services, but not from your practice ('B1'); 3. a patient has received more than two services, of which fifty-one (51) percent or greater were received from a physician(s) outside of your practice ('D'); 4. a patient is deceased ('A01'); 5. a patient now resides outside of the practice catchment area ('B'); 6. a patient has received five core services from outside your practice during the past 6 months ('F'); 7. a patient no longer has MSP coverage ('A'); 8. a patient has two (2) or more services outside catchment area ('X1'); 9. a patient's last two (2) services were outside the catchment area ('X2')	Valid Reason (and reason code in brackets) for requesting that the Ministry not automatically remove a patient from the patient register: ('C') the patient saw another general practitioner while their usual practice/general practitioner was on vacation ('E') Ministry records are incorrect, and the patient has MSP coverage ('I') the patient lives outside the catchment area, but works or attends school in the catchment area ('S') the patient lives outside the catchment area, but requires special care available at your practice ('T') the patient was temporarily referred to another practitioner for a special condition ('U') the Ministry address for the patient is incorrect, and the patient lives in the catchment area. Regardless of whether you notify the Ministry of Health using your software or by telephone, ensure that you supply a valid reason (denoted in brackets).

Please note: The most common errors made in submitting registration records are:

'P7' missing data such as incomplete address (data entry error), bad claim format (software error)
'W1' postal code is missing or wrong format was used
'P9' postal code is outside the practice catchment area, or the postal code is not recognized
'HV' the patient is already registered with the practice.

Questions and Answers

Q: *How do I record claims for core services provided to nonregistered patients when a physician is acting as "doctor of the day" at a hospital?*

A: A fee-for-service claim should be submitted for any core services that were provided. These patients will be considered "transient" patients, and therefore the third and any subsequent fee-for-service claims for services will *not* be reduced by 50%.

To ensure that the 50% payment reduction is not applied, the following claim information must be provided: (i) the referring physician's practitioner number (if no referring physician number is available, 99997 must be used in its place); (ii) the practice's payee number; (iii) a service location code ('H', 'I', 'E' or 'P'), and (iv) a "note record" stating that care was provided to a "doctor of the day patient", and the name of the hospital where the service was provided.

Q: *How do I record claims for core services provided to nonregistered patients who have been referred to the practice for prenatal care by the family physician, but will be returning to their family physician after delivery?*

A: A fee-for-service claim should be submitted for core services provided to the patient(s). The patient(s) will be considered "transient" patients, and therefore the third and any subsequent fee-for-service claims for services will *not* be reduced by 50%. To ensure that the 50% payment reduction is not applied, the following claim information must be provided: (i) the referring GP's practitioner number (ii) the service location code 'P' (outpatient), and (iii) your practice's payee number.

Q: *How do I record MSC fee code 03333 – "No Charge Referrals"?*

A: For registered patients, the "No Charge Referrals" can be submitted as either a patient encounter record or a fee-for-service claim. Submit a fee-for-service claim for nonregistered and transient patients.

Q: *When more than one care provider has seen a patient, do I submit one record, or one record per provider?*

A: If the health care professionals were working independently, then each provider should submit an encounter record (regardless of whether they provided similar, the same or unrelated service [s]).

If the health care professionals were working as a team (serving different team functions) during the patient encounter, then one encounter record should be submitted.

Q: *What do we do if there are changes to the composition of our health care team, or clinic location?*

A: You will need to notify the Ministry of Health of the changes. If the new member of your health care team does not already have a MSP practitioner number, contact the Medical Services Plan Practitioner Program (Tele: 250-952-3042) to obtain one.

A new facility number will be assigned to each clinic location where members of the practice's health care team are providing primary care to the practice's registered patients.

Q: *How do I submit data for core services provided as a result of a motor vehicle accident?*

A: When a physician provides a motor vehicle accident-related core service to a registered, nonregistered , or transient patient, the data record should be submitted as a fee-for-service claim. If the data is submitted as a $0 patient encounter record it will be refused with an explanatory code indicating that it should be re-submitted as a fee-for-service claim.

Q: *How do I submit Workers" Compensation Board claims and forms?*

A: There are two steps.

Step 1:
WCB forms should be faxed directly (and as soon as possible) to the Workers' Compensation Board. Ensure that the practice's payee number (and not the individual physician's payee number) is on the form.

Step 2
WCB claims should be electronically submitted as a fee-for-service claim using Teleplan. Ensure that the "insurer" on the claim is WCB, and follow all the WCB guidelines for submission of claims via Teleplan.

A Teleplan review will ensure that the claim format is complete and formatted correctly. If the claim is acceptable, it is then forwarded to WCB for reconciliation with the WCB forms. Teleplan will return the WCB's response to the practice in the standard Teleplan remittance file.

Q: *What happens if ICBC refuses responsibility for a claim, and that claim was for a core service to a registered patient?*

A: The Medical Services Plan will create a fee-for-service debit record to recover the fee-for-service payment made to the practice, and create an encounter "credit" record (showing $0 payment). The practice will be notified of the change through Teleplan on the next remittance statement.

Q: *How do I submit claims related to the care of a newborn?*

A: If the newborn does not have his/her own Personal Health Number (PHN), a fee-for-service claim should be submitted under the mother's PHN (with dependent code 66) for any services provided. The fee-for service claim should be accompanied by a "Note Record" explaining why you are unable to submit the claim under the newborn's own PHN.

If the newborn has a personal health number, then it is recommended that the practice register him/her as soon as possible. That is, the newborn is considered a nonregistered patient, and therefore fee-for-service payment for the third and any subsequent core service within a six-month period will be reduced by 50%.

Q: *Since population-based funding is calculated based on the patient's health status, correct ICD-9 coding is important. Can you provide examples of how to use the three ICD-9 fields now available for patient encounter records?*

A: Main Diagnostic Code: (Provision of this code is mandatory). This main diagnostic code represents the principle diagnosis i.e., the patient's condition as established after assessment, which is the primary reason for the patient's visit to the practice, and clearly most severe and demanding of resources.

Second Diagnostic Code: (Provision of this code is optional). This code represents a patient condition that coexists with the main diagnosis (e.g. a chronic underlying condition).

Third Diagnostic Code: (Provision of this code is optional). This represents another patient condition identified during the visit at the practice.

Q: *Are there any existing guidelines available that can help our practice choose the correct codes for recording services and procedures provided to patients?*

A: Yes, you can obtain the following resources by telephoning the Teleplan Helpdesk at 1-800-663-7206:

- Medical Services Plan's *Resource Manual for Physicians* (especially Section 6.1 General Billing Information)
- Medical Services Commission's *Payment Schedule* (especially Section 1, Preamble)

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Glossary

Adjusted Clinical Groups (ACG) – a series of mutually exclusive, health status categories which are defined by morbidity, age and gender as defined by the Johns Hopkins University Adjusted Clinical Groups case-mix adjustment system.

Blended funding – uses a population-based funding method, while maintaining a fee-for-service component for certain types of medical services, and for certain types of patients.

Core services – medical services that all GPs are expected to provide in the delivery of comprehensive primary care. Core services are used in the calculation of a practice's population-based funding.

Needs adjustment – setting funding level based on the health status of the patient.

Non-core service – any medical services not included in the group of core services (including anaesthesia, obstetric, and emergency services). Payment for non-core services remains fee-for-service.

Population-based funding – a practice income calculated on the basis of the number of patients (and their health needs/ACG) registered with a practice.

Practice – a primary care organization established as part of the Primary Care Demonstration Project (PCDP).

Practice catchment area – the Local Health Area in which the practice is located, and any adjacent Local Health Area from which a patient can reasonably be expected to use the practice as their main source of primary care.

Registered patients – patients who live in the practice's catchment area, and who receive the majority of their core services from the practice.

Nonregistered patients – patients who live in the practice's catchment area, but do not receive the majority of their primary care from the practice are considered nonregistered patients.

Service outflows – fee-for-service payments made to another practice located in the same catchment area for core services provided to a practice's registered patient.

Transient patients – patients who do not live in the practice's catchment area and do not receive the majority of their primary care from the practice.